

FILED AUG 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24455

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3450

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City				c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Research Hosp.				Length of stay in lb 45 Yrs.		d. STREET ADDRESS 4306 Bellefontaine	
3. NAME OF DECEASED (Type or print) MATIE R. CAULK				4. DATE OF DEATH Month 7 Day 20 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1868	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 89		11. BIRTHPLACE (City and state or country) Bloomington, Ill.	
13a. FATHER'S NAME Riley Ross				13b. MOTHER'S MAIDEN NAME Eliza Jackson		14. NAME OF HUSBAND OR WIFE Henry T. Caulk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Omer H. Caulk	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hemorrhage stomach DUE TO (c) (Cause undetermined)				INTERVAL BETWEEN ONSET AND DEATH 2 days Several mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - 491X							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Nov. 20-1857 to 7-20-57 and last saw her alive on 7-20-57 Death occurred on 7-20-57 m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE B. Atcheson M.D. (Physician or title)				22b. ADDRESS 3839 Maple		22c. DATE SIGNED 7-22-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-23-57		23c. NAME OF CEMETERY OR CREMATORY Green Lawn		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR Freeman Mortuary				ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 7-23-57	
				26. REGISTRAR'S SIGNATURE Hera Minshall			

3939 PROSPECT
WA. 4-6110

1-5130

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.